Western Cape Government

Referral to Intermediate Care Facility: PAEDIATRIC PATIENT

Please complete in legible handwriting / typed

CLIENT'S PERSONAL INFORMATION (Hospital sticker to be used)		
Name and Surname		
Date of Birth		
Age		
Gender	Male	Female
Contact number		
Responsible relative & relation to patient		
Nationality & Home language		

REFERRING FACILITY INFORMATION	
Referring Health worker (name and designation)	
Health Worker contact number	
Health Worker email address	
Referring facility	
Hospital /PHC Folder number	
Department	
Ward	
Responsible relative	

REASON FOR REFERRAL (tick appropriate box)							
Restorative and Rehabilitation		Palliative Care		Wound Care		Convalescent Care	
Post-Acute Care		Respite Care		Nutritional Care			

SECTIONS TO BE COMPLETED:

A. **Medical Report: Medical practitioner/ professional nurse to complete this section**
B. **Nursing Care Report: Medical practitioner/professional nurse to complete this section**
C. **Rehabilitation Report: Attending allied health professionals to complete this section**
D. **Social Workers Report: Social Worker to complete this section**

Admission Criteria:

- Patient must be 17 years and 11 months and younger
- Patient who still require care follow an acute hospital treatment who are not well enough to be discharged home.
- Patients requiring rehabilitation with a fair to good prognosis.
- Patients requiring palliative care where symptom and pain control is required.
- Patients with complex and or chronic wounds that would benefit from reducing or eliminating causative factors and who require systemic and topical support for healing.
- Patients who need respite care.

Exclusions:

- Clients who are clinically unstable/acutely unwell
- Clients who need Oxygen or require intravenous medication or fluids
- A Clients still requiring special laboratory investigations (if required by referring institution in preparation for follow-up appointment, then the name of the institution referring Doctor and Department should be filled on the laboratory form so that the lab can send these back to
- the referring sites) ll medical emergencies
- Clients who are pregnant (SA Nursing regulation 2598 – must be a doctor to manage pregnant women
- Clients arriving for admission outside admission hours as stipulated under requirement by referring entity
- Clients with active TB not yet on therapy
- Clients with MDR or XDR TB
- Highly infectious diseases
- Acute psychotic clients
- Clients with an expected ALOS (Length of Stay) of more than three – six months requiring long-term specialized , in- patient rehabilitation

SECTION A: MEDICAL REPORT				
Date of admission to referring facility			Date of discharge from referring facility	
Clinical Summary				
Past medical and surgical history as well as baseline prior to this admission				
Clinical summary of this admission including relevant investigation and results (eg. Recent CXR/ MRI and results)				
GCS	E…..M…..V….. …………/15			
TB	Yes (DS or DR-TB)	No	Awaiting results	
	If yes- is patient should be on medication for 2 weeks before consideration for admission			
RVD status	RVD Reactive		RVD Non-Reactive	
	If RVD reactive Is patient(tick): on ART / ART still to be initiated? CD4 count ………….. / CD4 not known Has disclosure taken place? Yes / No			
Prognosis	Good	Fair	Poor	Guarded
Weight bearing status for any orthopaedic injuries	Injury	Mx	Weightbearing status	
Medication	Name	Dosage	Frequency	Duration

Attending Dr Name and Surname	Designation		Signature	
	Contact number		Date	

SECTION B: NURSING REPORT				
Orientation and General Nursing (tick)				
Is patient confused?	Yes		No	
Is patient aggressive?	Yes		No	
Intake	***Feeding route (please tick)***			
	NGT	Oro-gastric tube	PEG	
	Please complete for NGT/peg patients			
	Name of feed:	Continuous / Bolus	Feeding rate:	
Tracheostomy	Yes	No	Trache closed	
Is patient on oxygen?	Yes	No	If yes: Was application done for home oxygen?	
Bladder	Continent		Incontinent	
Bowel	Continent		Incontinent	
Catheter	Yes		No	
	If yes: indewelling / Intermittent Managed by (tick): self / nursing staff			
Body weight	Underweight	Normal	Overweight	Obese
Does the client have road to health booklet?	Yes		No	
Are immunisations up to date?	Yes		No	
Most Recent treatment	Vitamin A:		Deworming:	
Wounds				
Wounds	Patient has surgical wound/s?	Yes	No	
	Patient has pressure sore?			
	Location of wound/s			
	Wound condition			
	Wound size and depth			
	Dressing / ointment used			

	Where did pressure sore originate?	Home		At facility
Attending Nursing Professional Name and Surname	Designation		Signature	
	Contact number		Date	

SECTION C: FUNCTIONAL REPORT ***(Please include standardised assessments if used)***				
Is patient able to participate in a rehab programme?	Yes		No	
Is patient orientated?	Yes		No	
Is short-term memory intact?	Yes		No	
Motivation	Poor	Average	Good	Excellent
Baseline functioning	Poor	Average	Good	Excellent
Current functional ability (tick)				
	Dependent	**Physical / Verbal Help**	**Supervision**	**Independent**
Eating / Drinking				
Dressing				
Communication				
Walking				
Wheelchair mobility				
Assistive Devices (tick)				
	Walking frame	Crutches	Quadropod	Walking stick
	Wheelchair / Buggy	Splint	AFO	AAC board
	Hearing aid	Visual Aid	Other:	
Was device issued?	Yes		No	
REHABILITATION REPORTS				
Occupational Therapy				
Did OT see patient?	Yes *(complete below)*		No / Not indicated	
Describe current level of function				
Progress				
How long was treatment given				
Attending Occupational Therapist Name and Surname	Designation		Signature	
	Contact number		Date	

<table>
<tr><th colspan="3">Physiotherapy report</th></tr>
<tr><td>Was patient seen by PT?</td><td>Yes (complete below)</td><td>No / Not indicated</td></tr>
<tr><td>Describe current level of function</td><td colspan="2"></td></tr>
<tr><td>Progress</td><td colspan="2"></td></tr>
<tr><td>How long was treatment given</td><td colspan="2"></td></tr>
<tr><td rowspan="2">Attending Physiotherapist
Name and Surname</td><td>Designation</td><td>Signature</td></tr>
<tr><td>Contact number</td><td>Date</td></tr>
<tr><th colspan="3">Speech Therapy and or Audiology Report</th></tr>
<tr><td>Did ST/Audio see patient?</td><td>Yes (complete below)</td><td>No / Not indicated</td></tr>
<tr><td>Describe current level of function</td><td colspan="2"></td></tr>
<tr><td>Progress</td><td colspan="2"></td></tr>
<tr><td>How long was treatment given</td><td colspan="2"></td></tr>
<tr><td rowspan="2">Attending Speech therapist / Audiologist
Name and Surname</td><td>Designation</td><td>Signature</td></tr>
<tr><td>Contact number</td><td>Date</td></tr>
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<table>
<tr><th colspan="3">Dietitian Report</th></tr>
<tr><td>Was patient seen by DT?</td><td>Yes</td><td>No / Not indicated</td></tr>
<tr><td>Current intake and feeding requirements</td><td colspan="2"></td></tr>
<tr><td>Progress</td><td colspan="2"></td></tr>
<tr><td>Recommendations</td><td colspan="2"></td></tr>
<tr><td rowspan="2">Attending Dietitian
Name and Surname</td><td>Designation</td><td>Signature</td></tr>
<tr><td>Contact number</td><td>Date</td></tr>
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Psychiatry/ Psychology assessment		
Does the patient have any psychiatric/ psychological concerns?	Yes: please specify details / attach detailed report	No
Did the patient receive psychiatric/ psychological intervention in the past?	Yes: please specify details / attach detailed report	No
Recent Stressful events		
Noticeable behaviour change		
Is the patient on any medication?	Yes: *Please indicate dosage and frequency*	No
Future recommendations		
Attending Psychologist / Psychiatrist Name and Surname	Designation	Signature
	Contact number	Date

SECTION D: SOCIAL WORK REPORT				
Family Background information				
In whose care is the patient currently placed?				
Biological Mother Name and Surname	Address			
	Contact number			
Biological Father Name and Surname	Address			
	Contact number			
Other relative/ Cargiver Name and Surname and relation to patient	Address			
	Contact number			
Siblings	**Name, Age and Gender**		**Same / other medical condition**	
Family Background (tick)				
Living Situation	Alone	With family	In facility	Other
Housing conditions	No fixed abode	Self-owned	Renting	Formal / Informal
Financial Status	Foster care grant	Care Dependency grant	Child support grant	Income: R0-R4000 R4001-R8000 > R8000
Type of grant to be applied for / already applied for	Foster care grant	Care Dependency grant	Child support grant	Date of application
Schooling details				
Does the client attend school?	Yes		No	
If yes:	Name of School			
	Last grade attended			
	School contact number			
Will the parent be accompanying the client to the intermediate care facility?	Yes		No	
future planning (tick)				
Client support needs	Psychosocial support	Family Education	Mental Health Support	Substance misuse support
Client documentation needs	ID	Other:		
Other needs				

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<tr><td rowspan="2">Attending Social Worker
Name and Surname</td><td>Designation</td><td>Signature</td></tr>
<tr><td>Contact number</td><td>Date</td></tr>
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